Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,713.84 for date of service, 08/24/01.

   b. The request was received on 08/13/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92 (s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Contract information
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC-60 and a Response to the Request for Medical Dispute Resolution
   b. ASC Methodology
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 09/12/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/13/02. The response from the insurance carrier was received in the Division on 09/27/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. A Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

II. PARTIES' POSITIONS

1. Requestor: Letter dated 09/10/02

"(Requestor) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by (Requestor) is at a minimum of 70% of billed charges. This is supported by a managed care contract with (healthcare plan) that is attached as Exhibit 1. This managed care contract supports (Requestor's) argument that the usual and customary charges are fair and reasonable and at the very least, 70% of the usual and customary charges is fair and reasonable. This managed care contract exhibits that (Requestor) is requesting reimbursement that is designed to ensure the quality of medical care and to achieve effective medical cost control as the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers [sic] medical services. As a result, the reimbursement requested by (Requestor) is not in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, as evidenced by the managed care contract attached….the treatment rendered was reasonable and necessary in accordance with the usual and customary standards of the medical community for the treatment of the compensable work-related injury and under the appropriate Treatment Guidelines."

2. Respondent: Letter dated 09/27/02

"…the Requestor seeks additional reimbursement for an ambulatory surgical service in the form of Left Lumbar Sympathetic Block delivered to the Claimant on August 24, 2001. The total amount billed was $5,353.84. The Respondent audited the bills and paid a fair and reasonable amount of $544. The Respondent received a Request for Reconsideration on January 25, 2002, and issued a supplemental payment in the amount of $96. The total amount in dispute is $4,713.84…. Respondent bases its reimbursement rate upon surgical codes as indicated on the HCFA 1500. Payment is based upon the Medicare methodology when the billed procedure codes are included within the ASC payment groups. The Respondent uses the St. Anthony APC/ASC payment manual to determine the ASC group for the procedure, and then selects the allowable payment assigned to that group. Based upon the mean reimbursement of the Respondent's contracts with Houston ASCs, the Respondent increases the payment by 70% to allow for a sufficient increase to accommodate index variations of various geographical locations. For the first procedure, the Respondent reimburses at 100% of the ASC group rate plus 70% of that amount. For second and subsequent procedures, the reimbursement rate is 50% of the ASC group plus 70% of that amount. (After December 1991, the ASC reimbursement is as above, but pays the Medicare group allowances plus 100%."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/24/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,353.84 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $544.00 for services rendered on the date of service in dispute above. The carrier has supplied information that indicates a supplemental payment of $96.00 was recommended on reaudit, dated 02/15/02.

5. The Carrier's EOBs denied any additional reimbursement as "M-Reduced to Fair and Reasonable."

6. The amount in dispute is $4,713.84 for services rendered on the date of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…."

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (i) (1-4) places certain requirements on the Carrier when reducing the billed amount to fair and reasonable. Also, Rule 133.307 (j) (1) (F), discusses the requirements for the carrier when responding to a request for dispute resolution. The burden is on the provider to show that the amount of reimbursement requested is fair and reasonable.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine which party has provided the most persuasive evidence of what is fair and reasonable. The Carrier has submitted evidence as to how they determined their reimbursement amount. A methodology was submitted as required by Rule 133.304 (i). The Provider, who has the burden as the Requestor, to prove its fees are fair and reasonable submitted a copy of a managed care contract indicating payment of 70% was to be paid. However, that contract is 10 years old. It does not provide current information. The provider indicates in its position statement that EOBs were attached, however, none were found in the dispute packet The information submitted does not discuss, demonstrate, or justify why the Requestor's fees are fair and reasonable as required by Rule 133.307 (g) (3) (D). The Provider has not provided sufficient information that supports its fees billed are fair and reasonable. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

References: Rule 134.401 (a) (4); Rule 133.307 (g) (3) (D); Rule 133.304 (i); Rule 133.307 (j) (1) (F); § 413.011 (d).

The above Findings and Decision are hereby issued this 7th day of April 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division
CO/co